

HEALTH ASSESSMENT

Presented to:
Dr. Pallavi Pathania
Assistant Professor
Medical Surgical Nursing
Shimla Nursing College

Presented by:
Reena Sharma
M.sc.(Nursing) 1st year
Shimla Nursing College
Annandale, Shimla

INDEX

SR.NO.	CONTANT
1	Introduction
2	Terminology
3	Health assessment
4	Health history
5	Physical examination
6	Summarization
7	Conclusion
8	Recapitalization
9	Bibliography

HEALTH



INTRODUCTION

Health is a physical ,Mental. and social wellbeing, and as a resource for living a full life.it refers not only to the absence of disease, but the ability to recover and bounce back from illness and other problems.

DEFINITION

Health is the state of complete Physical, mental and social wellbeing and not merely an absence of disease or infirmity.

(ACCORDING TO WHO)

ASSESSMENT



INTRODUCTION

Assessment is a wide variety of methods of tools that educators use to evaluate, measure, and document the academic readiness, learning progress, skill acquisition, or educational needs.



DEFINITION

Assessment is the deliberate and systematic collection of data to determine clients current and past health status, functional status and to determine client's present and coping pattern.

(Carpenito)

TERMINOLOGY

- **Diagnosis – It is the determination of the nature and extent of a disease.**
- **Prognosis – It is the forecast of the course and duration of a disease.**
- **Etiology – It is the science of the cause of a disease.**
- **Signs – The presence of a disease that can been seen or elicited E.g. Fever.**
- **Symptoms – Any evidence as to the nature and location of a diseases noted by client.**

CONT..

- **Subjective symptoms- – When the symptoms are noted by the client himself. e.g. Pain**

- **Objective Symptoms – When the symptoms are noted by the observer as well as by the client. E.g. Jaundice**

HEALTH ASSESSMENT



DEFINITION:

Health assessment is an organized systematic assessment of human body which involves the use of one's senses to determine the general physical and mental conditions of the body by collecting both subjective and objective data.

PURPOSE OF HEALTH ASSESSMENT



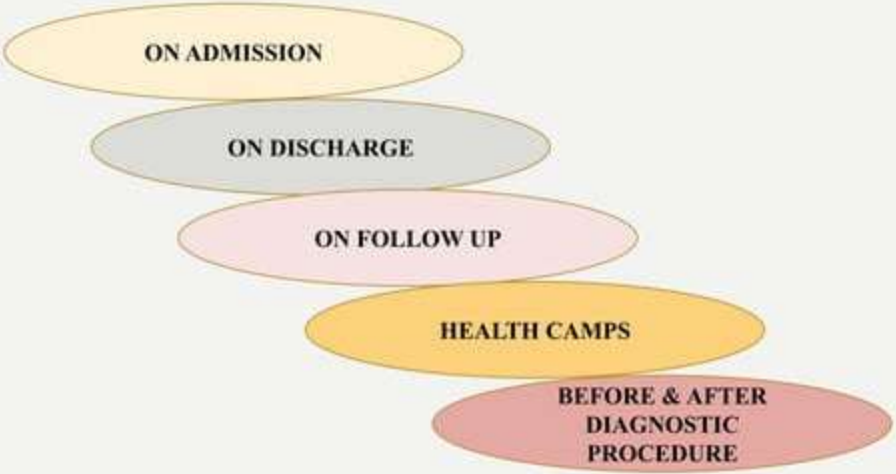
- To establish a data base of client's normal abilities, risk factors that can contribute to dysfunction and any current alteration in function.
- To get a clear picture of a client's health status and health related problems.
- To identify cause and extent of disease.
- To identify the problems at early stage.
- To determine the nature of treatment required for the client.

CONT..



- To get a holistic view of the client.
- To contribute in medical research.
- To identify client's strength, weakness, knowledge, attitude, motivation, support systems and coping skills.
- To compare client's health status with a ideal status.

INDICATION OF HEALTH ASSESSMENT



COMPONENTS OF HEALTH ASSESSMENT




HEALTH HISTORY

A1. HEALTH HISTORY

- It is a collection of subjective data in detail regarding client's health in a chronological order.
- It is a component of health assessment.
- Health history is supplying essential information that will assist with diagnosis, and establishment of trust and rapport between lay persons and medical professionals.



FACTORS AFFECTING THE COLLECTION OF SUBJECTIVE DATA

- Physical setting
- Client's personality and behavior
- Nurses personality and behavior
- Communication skill
- Patient's problem





FORMAT OF HEALTH HISTORY

- Biographic data
- Chief complaints
- History of present illness
- Past health history
- Family history
- Occupational and environmental history
- Psychological history
- Review o system



IDENTIFICATION DATA

- Name .....
- Address .....
- Gender .....
- Age .....
- Marital Status .....
- Occupation .....
- Religion .....
- Family Income (Monthly) .....
- Educational Qualification .....
- Diagnose .....



CHIEF COMPLAINTS:

- It is a brief assessment of client's problem for which clients seeks medical care.
- It should be written in clients statement.
- A description of onset and duration of problem.



HISTORY OF PRESENT ILLNESS

- Onset
- Sign and symptoms (S&S)
- Duration
- Treatment taken (if any)
- Other complaints such as :
  - -loss of appetite
  - -insomnia
  - -Disorders of stomach etc.
- Client's health habits- eating, sleeping etc.



PAST MEDICAL HISTORY

- ✓ **CHILDHOOD ILLNESS** -MUMPS, MEASLES AND SO ON
- ✓ **ALLERGIES** -
- ✓ **MEDICAL DISEASE** - HTN,DM, ANEMIA
- ✓ **SURGERY** - ANY H/O SURGERY
- ✓ **HOSPITALIZATION** -ANY HOSPITALIZATION IN THE PAST
- ✓ **OBSTERTRIC HISTORY** - NO. OF LIVE BIRTH , ABORTION, MODE OF DELIVERY



PAST SURGICAL HISTORY

Past surgeries provides information about what surgical problems the patient has had in the past and potential problem that might be in the patient's future.

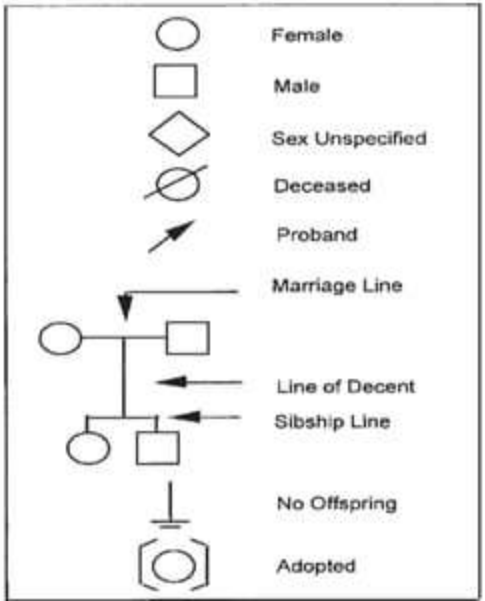
Ask patient about their past surgical history.

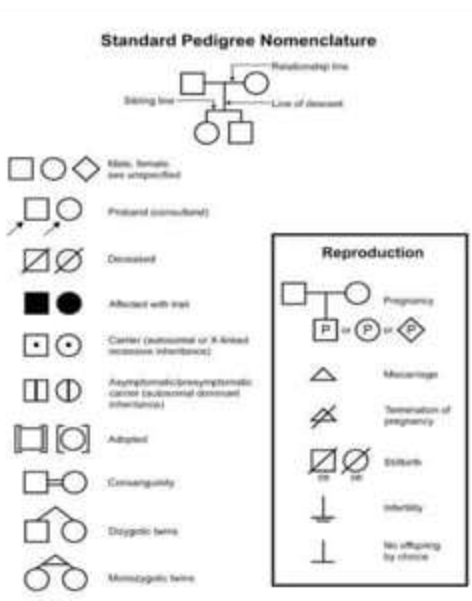
e.g. time / place /what type of operation.

Note any blood transfusion / blood grouping



FAMILY TREE


Female
Male
Sex Unspecified
Deceased
Proband
Marriage Line
Line of Decent
Sibship Line
No Offspring
Adopted


Standard Pedigree Nomenclature
Relationship line
Sibling line
Line of descent
Male, female, sex unspecified
Proband (consultand)
Deceased
Affected with trait
Carrier (autosomal or X-linked recessive inheritance)
Asymptomatic/presymptomatic carrier (autosomal dominant inheritance)
Adopted
Consanguinity
Dizygotic twins
Monozygotic twins
Reproduction
Pregnancy
Miscarriage
Termination of pregnancy
Stillbirth
Infertility
No offspring by choice

CONT...

- Family tree (pedigree chart)
- Information about family members
- Family history of any illness (Diabetic mellitus, Hypertension etc.)
- **PEDIGREE CHART**

SR.NO.	NAMEOF FAMILY MEMBER'S	AGE	SEX	RELATION	HEALTH STATUS

OCCUPATIONAL HISTORY

- Collecting data regarding clients job:
  - -nature of job,
  - -environment of job
  - -exposures to any hazardous substance (if any)



PSYCHOSOCIAL HISTORY

- Smoking and Alcoholism
- Food habits and foot fads
- Like and dislike
- Patterns of sleep
- Exercises








PHYSICAL
EXAMINATION

2.PHYSICAL EXAMINATION

- Physical examination is defined as a complete assessment of a patient's physical and mental status.
- A physical assessment is the systematic collection of objective information that is directly observed or is elicited through examination techniques.



ROLE OF NURSE IN PHYSICAL EXAMINATION

❖PREPARATION OF ENVIRONMENT

- MAINTENANCA OF PRIVACY: A separate examination room is needed, keep the door closed. The relatives are not allowed.
- LIGHTING: There should be adequate lighting.(natural lighting).
- COMFORTABLE BED OR EXAMINATION TABLE: The client should be placed comfortably throughout the examination



- PREPARATION OF THE EQUIPMENT

- PRAPARTION OF THE CLIENT
  - PHYSICAL PREPARTION
  - MENTAL PREPARATION





TEHNIQUES OF PHYSICAL EXMINATION

1. INSPECTION
2. PALPATION
3. PERCUSSION
4. AUSCULTATION
5. OLFACTION



OTHER TECHNIQUE OF PHYSICAL ASSESSMENT

6. MANIPULATION

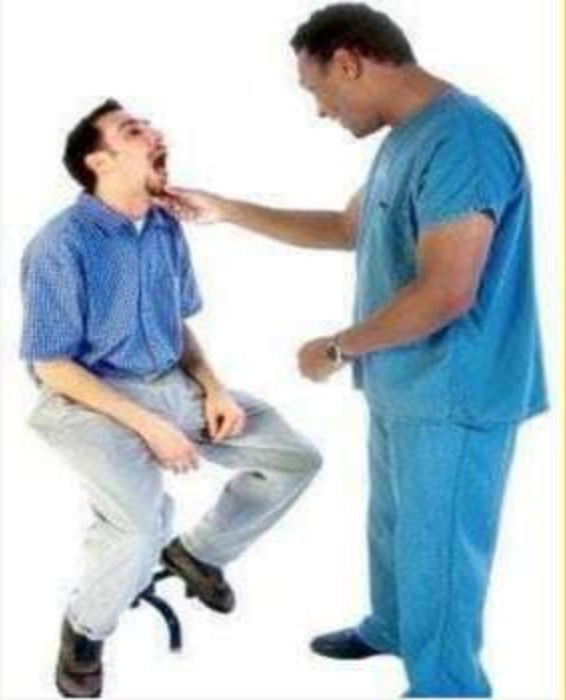
7. REFLEX TESTING



1.INSPECTION

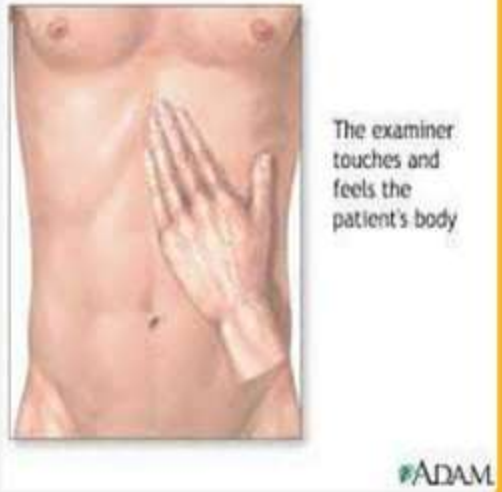
It is one technique of physical examination. It is process of visual examination and observation of the body. This including body position and shapes.

e.g. look for bruising, cut, moles etc.



2.PALPATION

Palpation is a process in which healthcare provider uses their hands to feel certain parts of the patient's body. It is used to identify areas that the patients reports to be a tender or painful.



TYPES OF PALPATION:

LIGHT PALPATION

- The practitioner presses to a depth of 1 cm.
- e.g. pulses



DEEP PALPATION

- The practitioner presses to a depth of 4 cm.
- e.g. Feel organ size & shape



3.PERCUSSION

This is when the examiner uses their hands to "tap" on an area of your body. The "taping" produces different sounds. Depending on the kind of sounds that are produce over the abdomen, on your back or chest wall.

e.g. ascites



4.AUSCULTATION

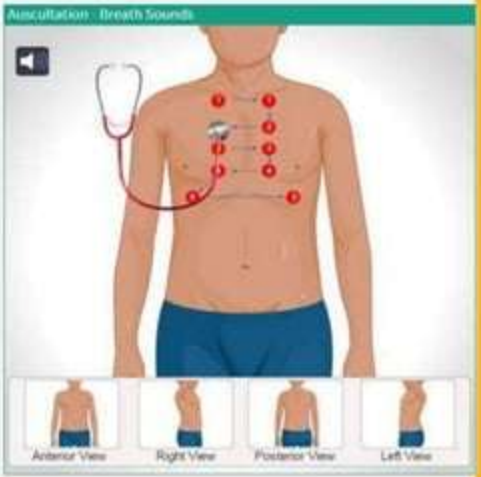
- This is a important technique used by you healthcare provider, where he or she will listen to your heart, lungs, neck or abdomen, to identify if any problems are present. Auscultation is often performed by using a stethoscope.
- E.g. Murmur sound in heart.

  Wheezing sound in lungs



CONT..

- **Four Characteristics of sound are assessed by auscultation;**
  - Pitch (Ranging from High to low)
  - Loudness (Ranging from Soft to Loud)
  - Quality (Gurgling)
  - Duration (Short, Medium or Long)



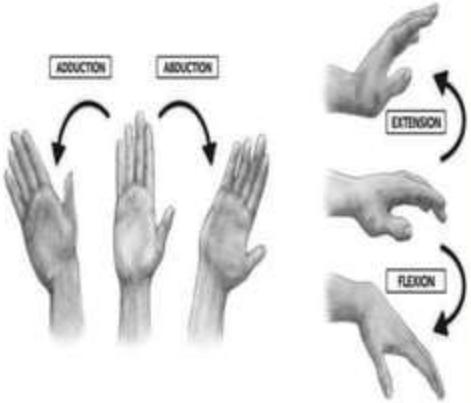
5. OLFACTION

- Olfaction is the action or capacity of smelling; the sense of smell.
- The nurse's olfactory sense provides vital information about a patient's health status.
- It helps to detect abnormalities not recognized by other means.
- E.g., if a patient cast has a sweet, heavy, thick odour, this indicate an underlying infection.



6.MANIPULATION

It is the moving of a part of the body to note its flexibility. Limitation of movement is discovered by this movement.



7.REFLEX TESTING

- **Testing of reflexes**

The response of the tissues to external stimuli is tested by means of a percussion hammer, safety pin, wisp of cotton or hot and cold water.



ARTICLES FOR HEAD TO TOE EXAMINATION

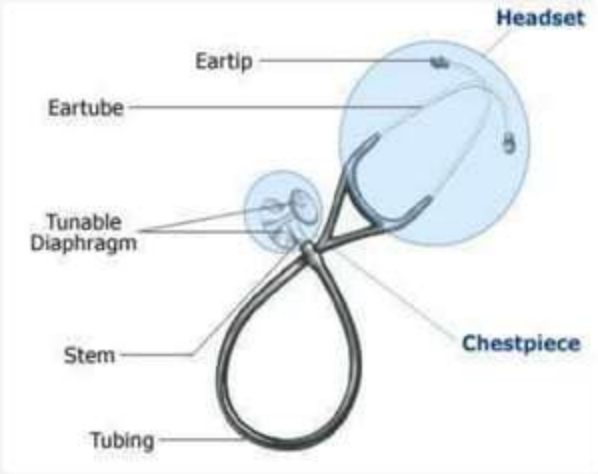
Articles	Purpose
Sphygmomanometer	To measure B.P
Stethoscope	To listen the Body Sound
Foetoscope	To listen the F.H.S
T.P.R Tray	To assess the vital signs
Tongue Depressor	To examine the mouth and throat
Pharyngeal Retractor	To examine the pharynx
Laryngoscope	To examine the larynx
Tape Measure	To measure height, weight and abdomen circumference
Flash Light	To visualize any part
Weighing Machine	To check the weight
Ophthalmoscope	To examine the inner part of eyeball
Otoscope	To examine the ear
Turning Fork	To test the hearing

CONT..

Articles	purpose
Nasal speculum	To examine the nostrils
Percussion hammer	To test refluxes
Vaginal specula	To examine the genitals of women
Proctoscope	To examine the rectum
Gloves	To examine the pelvis internally
Sterile specimen sample	To collect specimen if necessary

EQUIPMENTS

1. STETHOSCOPE





2.OPTHALMOSCOPE



3. OTOSCOPE



4. NASAL SPECULUM



5. VAGINAL SPECTULAM



6. TUNING FORK



7.PERCUSSION HAMMER

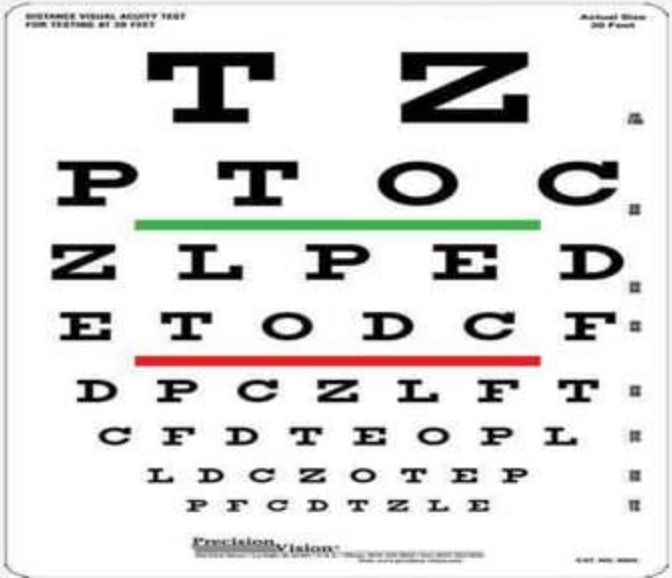


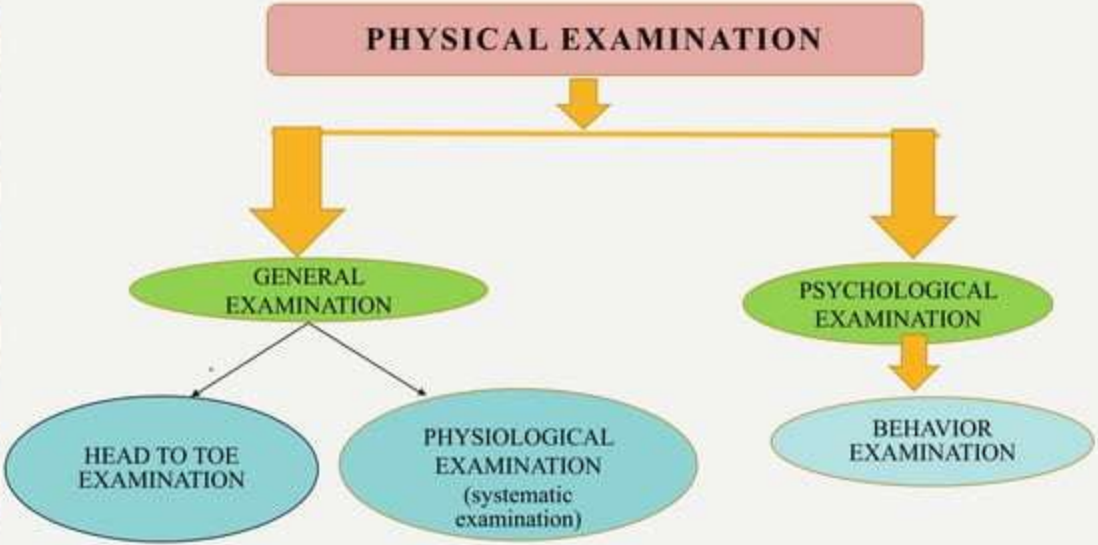
8. SPHYGMOMANOMETER





SNELLEN'S CHART




PHYSICAL EXAMINATION
GENERAL EXAMINATION
PSYCHOLOGICAL EXAMINATION
HEAD TO TOE EXAMINATION
PHYSIOLOGICAL EXAMINATION
(systematic examination)
BEHAVIOR EXAMINATION

HEAD TO TOE EXAMINATION

General appearance : Depressed and anxious

Nourishment : Well nourished.

Body build : normal body build

Mental status : conscious, unconscious, delirious, talking incoherently

GLASGOW COMA SCALE

BEHAVIOR	`	SCORE	PATIENT SCORE
Eye Opening Response	4 Spontaneously 3 To speech 2 To pain 1 No response	4	4
Best Verbal Response	5 Oriented to time, place and person 4 confused 3 inappropriate words 2 Incomprehensible sounds 1 No response	5	5
Best Motor Response	6 obeys commands 5 Move to localized pain 4 Flexion withdrawal from pain 3 Abnormal flexion (decorticate) 2 Abnormal extension (decelerate) 1 No response	6	6
TOTAL SCORE MINIMUM SCORE=3 MAXIMUM SCORE=15		15	15

ANTHROPOMETRIC MEASURMENT



Height : 5.4 feet

weight : 60 k/g

BMI : Weight in kg/height in m^2

$60/(1.65) = 60/2.72$

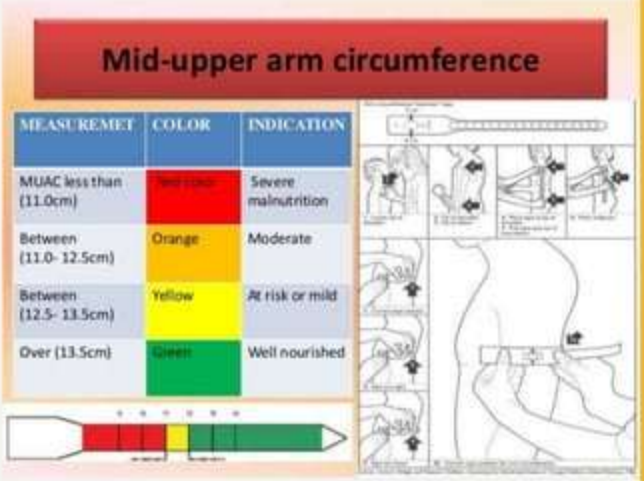
$=22.05kg/m^2$

Weight category	BMI	Remarks
Normal	18.5-24.9	$22.05kg/m^2$
Overweight	25-29.9	-
Obese	>30Above	-
Class-I	30-34.9	-
Class-II	35-39.9	-
Class-III	>40Above	-

HEAD TO TOE EXAMINATION

GENERAL APPEARANCE

- Level of consciousness -------
- Activity -------
- Body build -------
- Height -------
- Weight -------
- Mid upper arm circumstances: -------
- General grooming -------
- position /posturing -------
- Facial expression -------
- Body language -------
- Hygiene -------
- Nutritional status -------



HEAD

- Scalp Clean :yes/no.
- hair distribution and Characteristics:
-Color of hairs : black / white /brown.
-Pediculosis : yes / no.
-Any other problem detected specifically-------



EYES

-Alignment : parallel to each other or not.
-Eye brows: normal / absent
-Eye lashes ; infection / sty.
-Eyelids : edema / lesion / ectropion.
-Eye balls: normal / sunken / purulent.
-Sclera : pigmented / yellow.
-Pupil : equally react to light or not dilated / constricted.
-Eye muscles : squint
-Eyes : any discharge
-Spectacles:-------
-Contact lenses-------
-vision / normal / myopia / hypermetropia.



CONT…

EARS (INSPECTION)

-Using of hearing aids : yes / no .

-Appearance of auricles :-------

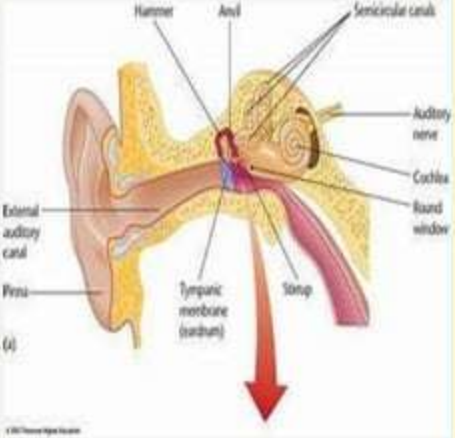
-Any lesion :-------

-Auditory canal: wax / nodules.

- Discharge------

(PALPATION)

-Auricle and mastoid process: pain and tenderness.



HEARING AND EQUILIBRIUM TESTS:

-Whisper test

-Weber's test

-Rinne test

-Romberg test





RINNE'S TEST



ROMBERG TEST



CONT...

NOSE:

-Nostrils : inflammation of mucus membrane.

-External nares : crusts / discharge.

-Septum : presence of nasal septum deviations .

- Discharge :

-Any abnormalities:

MOUTH :

-Lips : dryness / color / angular stomatitis.

-Teeth : no teeth ? Dental carries/

-Gums : color / ulceration / bleeding

-Buccal mucosa : pink (soft smooth indicate normal),
thick white patch indicate leucoplakia,
yellow pigmentation indicate jaundice .



CONT...

TONGUE :

-Color (Pale Dry / Lesions)

-Odour from mouth (foul odour) -------

-Tonsils : color / size / lesions. -------

THROAT:

-Inflammation:

-Pus:

-Any other observation:



NECK

- **Inspection**

  -Any abnormal swelling or masses:-------

  -Palpation (thyroid and cervical lymph nodes): :-------

  any other observation: :-------



CHEST

-Shape: :-------

-Breast : :-------

Inspection

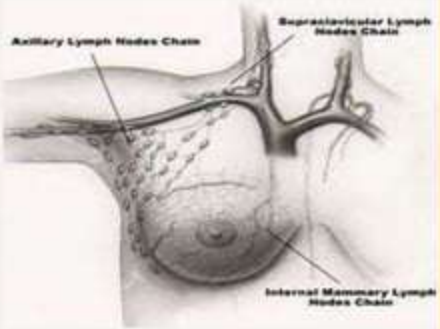
-(symmetry)/skin: :-------

-Nipple : :-------

Palpation (mass)

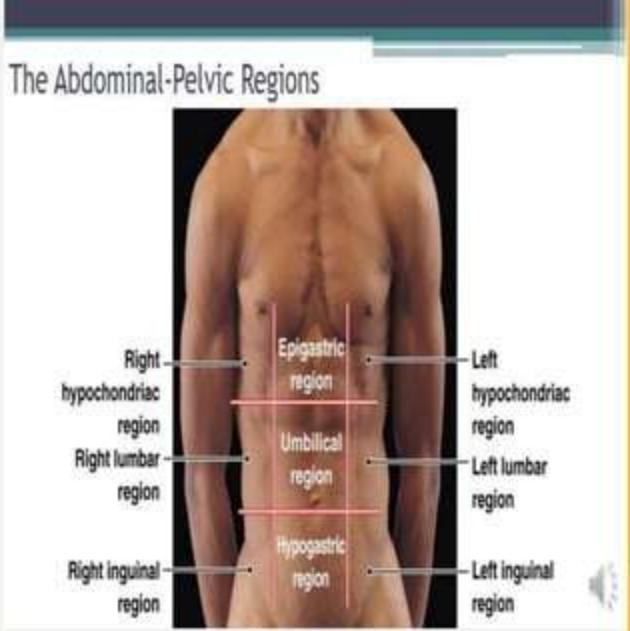
-Axillary lymph nodes: :-------

-Discharge from nipple: :-------



ABDOMEN

- Color:
- Skin texture :
- Distension :
- Tenderness :
- Visible movement :
- Any abnormalities:



BACK

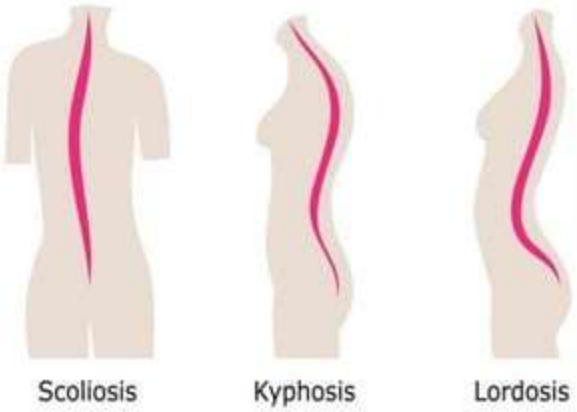
- Color:
- Lesion :
- Shape of vertebral column:
- Any other observation :

EXTREMITIES:

Symmetry :

Muscle strength and tone :

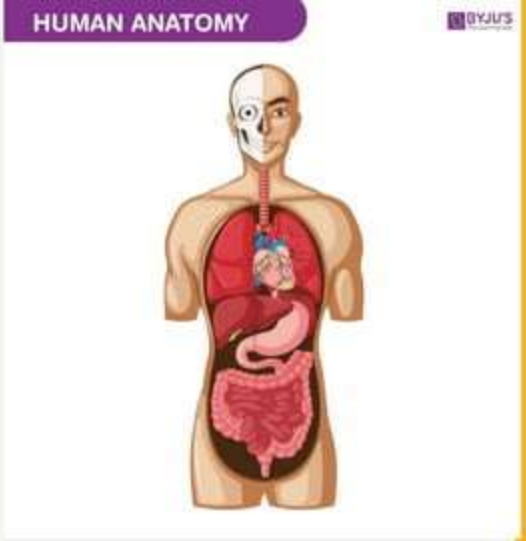
Any abnormalities:



SPINAL DEFORMITY TYPES

2) SYSTEMATIC EXAMINATION

Systematic examination review the major system of the body like the respiratory system, cardiovascular system, gastrointestinal system, genitourinary system, musculoskeletal system, nervous system, integumentary system.



2) SYSTEMIC EXAMINATION



RESPIRATORY SYSTEM

Inspection

-Patient is on :-------

-Symmetry : :-------

-Chest movement: :-------

-Respiratory rate :-------

-Endotracheal tube :-------

Palpation

-Assess chest expansion :-------

Auscultation

-Breath sound :-------(normal, wheezing. Ronchi

Percussion

-Flatness / dullness / resonance / hyperresonance: :-------

CARDIOVASCULAR

- **INSPECTION**

  -Pulsation (visible location) :-------

- **PALPATION**

  -Apical impulses :-------present / absent

- **PERCUSSION**

  -Cardiac dullness :------

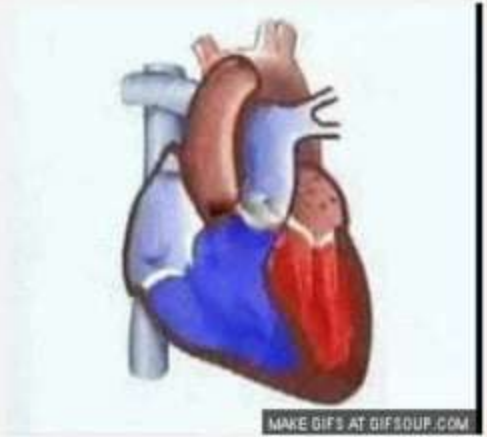
- **AUSCULATION**

  -Heart sound :-------

  - Heart rate :-------

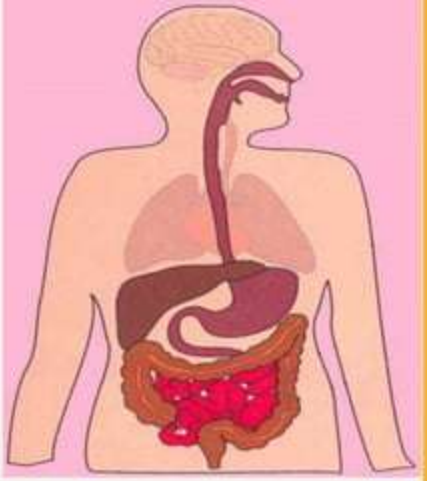
  -S1&S2 Sound :-------

  -Blood pressure :-------



GASTROINTESTINAL SYSTEM

- **Inspection**
  - -Skin texture :-------
  - -Color :-------
  - -Distension :-------
  - -Abdominal girth :-------
  - -Visible movement :--------
- **Auscultation :**
  - -Bowel sound :
- **Percussion :**
  - -Flatness /dullness /resonance / fluid thrill
- **Palpation**
  - - Light palpation for tenderness :--------
  - -Deep palpation for Splenomegaly :-------



GENITOURINARY SYSTEM

MALE GENITALIA:

-Urinary catheter: -------Present / absent,

-Inspect the size / shape / position of scrotum.--------

-Palpation for size / shape / tenderness of scrotum.--------

FEMALE GENITALIA:

-Urinary catheter:-------present / absent.

-Vaginal discharge:-------present / absent.

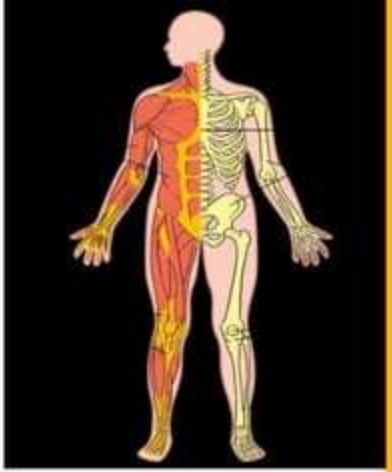
-Vaginal redness:------- present / absent.





MUSCULOSKELETAL SYSTEM

- Inspection :
- Symmetry
- Muscle strength
- Range of motion
- Any abnormalities (joint swelling, fracture, Dislocations, etc.)



MOTOR FUNCTION

- Balance and gait
- Romberg's test
- Motor function and coordination



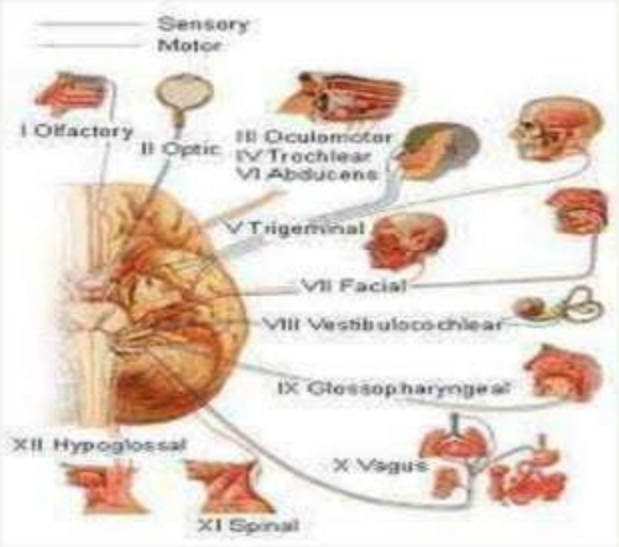
NERVOUS SYSTEM

- Describe tics, twitches, Paraesthesia :
- Gaits:
- Reflex:
- Accessory(cranial nerve CN X1:
- Coordination :
- Cranial nerves:



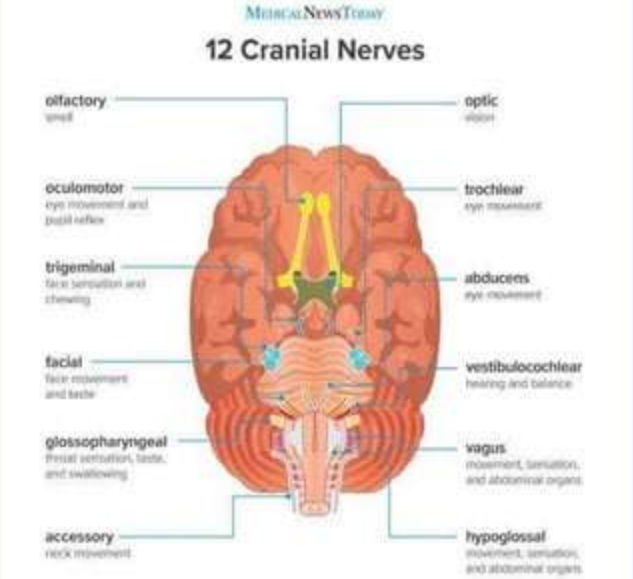
CRANIAL NERVE FUNCTION

- **Olfactory nerve(1):**
- **Optic nerve(2)**
- **Oculomotor(3)**
- **Trochlear(4)**
- **Trigeminal(5)**
- **Abducens(6)**



CRANIAL NERVE FUNCTION

- **Facial(7)**
- **Auditory(8).**
- **Glossopharyngeal(9)**
- **Vagus(10)**
- **Spinal accessory(11**
- **Hypoglossal(12)**



NEUROLOGICAL TEST'S

- ❑ Coordination tests
- ❑Equilibrium tests
- ❑Test for sensation

❑Reflex :

- Achilles tendon reflex
- Planter flexion
- Knee deep tendon

Cerebellar Function, *con't*

Nose –to - Finger Test



21

ACHILLES REFLEX

- **Ankle jerk reflex**, also known as the Achilles reflex, occurs when the Achilles tendon is tapped while the foot is dorsiflexed. It is a type of stretch reflex that tests the function of the gastrocnemius muscle and the nerve that supplies it.



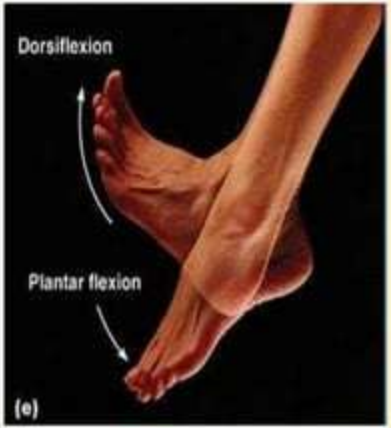
TEST FOR SENSATION

The sensory exam includes testing for: pain sensation (pin prick), light touch sensation (brush), The primary purpose of a sensory examination is to evaluate sensory integrity and to assess the distribution and characteristics of the sensory impairment.



PLANTAR FLEXION

Plantar flexion is a movement in which the top of your foot points away from your leg. You use **plantar flexion** whenever you stand on the tip of your toes or point your toes.



INTEGUMENTARY SYSTEM

Color: -Normal/ bluish (cyanosis) /pallor

(loss of pigmentation)

yellow/orange (jaundice) red (erythema).

-Moisture:

-Temperature :

-Vascularity and edema :

-Skin turgor :

-Skin texture :

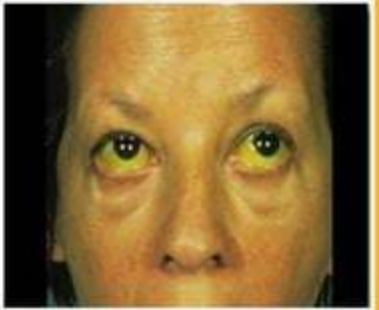
-Any lesion or breaks in skin integrity :

-Examination of nails :

-Color :

-Strength :





PALLOR



PSORIASIS:



URTICARIA(HIVES)



VITILIGO



PAPILLOMATOSIS:



PSYCHOLOGICAL ASSESSMENT

- It is a systematic procedure for obtaining samples of behavior, relevant to cognitive, affective, or interpersonal functioning, and for scoring and evaluating those samples according to standards.



TYPES OF PSYCHOLOGICAL TEST

- Individual and group test
- Paper pencil test and performance
- Language and non language test

INDIVIDUAL TEST :

- A test can be said individual test in the sense that they can be administered to only one person at a time.

e.g. interview



GROUP TEST :

- Group test can be administered to a group of a person at a time.

e.g. performance test



PAPER PENCIL TEST:

The subject is provides with a test booklet which contains all these items .responses are written by the subject on either the test form or on a separate answer sheet.



PERFORMANCE TEST:

Require motor or manual response on the examine part generally but no always, involving manipulation of concrete equipment or materials.

LANGUAGE TEST

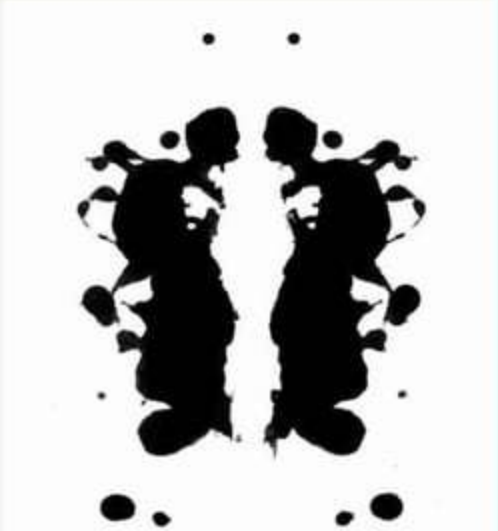
- In a paper –pencil language test, content generally contains of pictures, diagrams and the subject is required to respond by making relatively simple marks. Instructions are given by gestures, and demonstrations involving charts and diagrams.

NON LANGUAGE TEST:

- In this neither written nor spoken, in neither the instructions nor the test items is required. Non language tests areas specially designed for testees who are liiterate, unfamiliar with the native language, can either be a performance or a paper- pencil test.

INKBLOT TEST

The Ink Blot **Test** The inkblot **test** (also called the **"Rorschach" test**) is a method of psychological evaluation. Psychologists use this **test** in an attempt to examine the personality characteristics and emotional functioning of their patients.



ROLE OF NURSE'S IN PSYCHOLOGICAL TESTS:

- Should have knowledge about all the psychological tests.
- Clarify the patient's and relatives' doubts regarding the psychological tests they have to undergo.
- Nurses should have good rapport with the patients and family members.
- The nurse should observes the patient's behavior and the changes, which occur once the therapy is commenced.
- The nurse observes, informs and records these changes in patient's chart.
- The nurse can also interrupt the finding of various tests and then plan the nursing care accordingly.



DOCUMENTATION OF DATA



AFTER CARE OF THE PATIENT



AFTER CARE OF ARTICLES

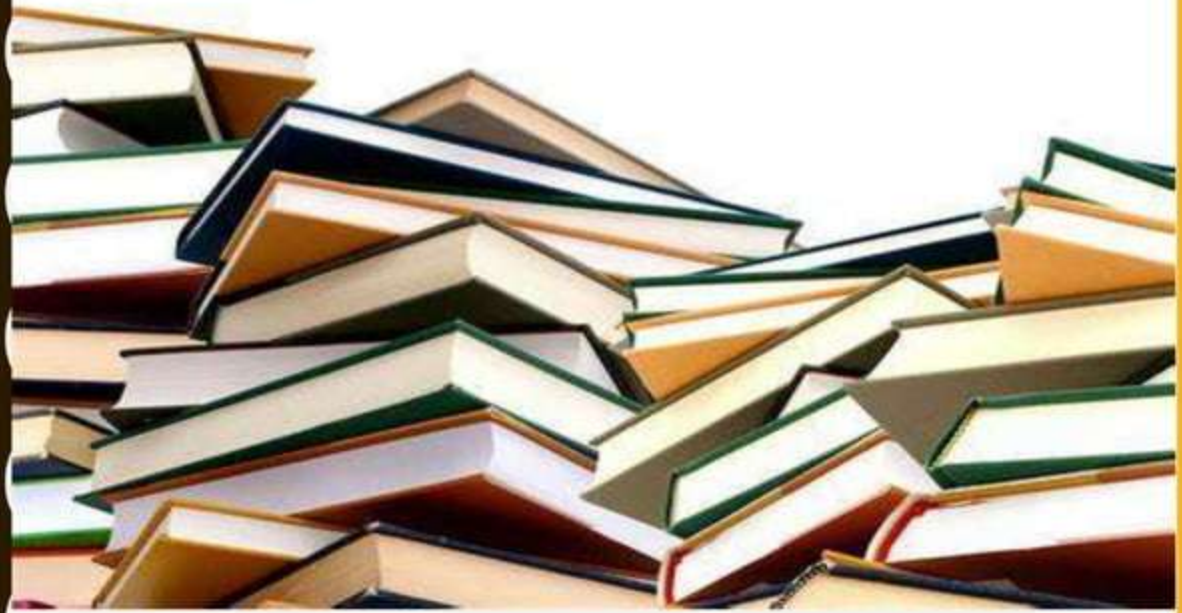


CONCLUSION

Health assessment is a systematic and organized process. It is pan of care that identifies the specific needs of a person.it can perform by two methods that is health history and physical examination.

In Health history collect detailed history from the patient or in the physical examination collect detained history by performing examination techniques.

SUMMERSATION:





RECAPITULATION:-

Q1.What is health assessment ?

Ans. Health assessment is an organized systematic assessment of human body which involves the use of one's senses to determine the general physical and mental conditions of the body.

Q2. Techniques of physical examination ?

Ans.1 Inspection

2.Percussion

3.Palpation

4.Auscultation

5.Olfaction

6.Manipulation

7.Reflex testing

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ASSIGNMENTS
DUE DATE
ASSIGNMENT
CLASS
DONE

ASSIGNMENT:

- What are the steps in physical examination?
- Write down the physical examination of patient suffering from fever.?





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